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ended and time-limited. These include such programs as Head Start, comprehensive health services projects, migrant health projects, Appalachian Regional Commission (ARC) health and child development projects, and Health Underserved Rural Areas (HURA) projects. Medicaid funds are to be used for services to Medicaid recipients provided under these programs and covered by the State plan. This is often referred to as the "first dollar" concept. It places on Medicaid the responsibility for using its funds up to the limits of the State plan on scope and amount of services, before looking to other programs to pay for medical care provided to Medicaid recipients.

2. Entitlement to Medical Care If Medicaid recipients are entitled to benefits from such sources as Medicare, CHAMPUS, VA medical services, or other hospital or health insurance, they must use these benefits before drawing on title XIX.

3. Payment for Services Available Without Charge From the outset, Medicaid has held to the principle that Medicaid funds may not be used for services that are free to everyone in the community. In this context, the word "community" is used variably. It may represent a State, a portion of the State, a city, or a particular classification of the population such as all

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school children. Some examples of services available without charge are public health services, school health programs, tuberculosis, venereal disease and other case-finding programs. Services available without charge, for purposes of Medicaid, means that no individual or family is charged for medical care, and third party reimbursement is not sought.

As third party payments have become available, agencies and organizations that provided services available without charge in the past now look to third party payors as one source of program support. The Medicaid agency is considered to be a "third party." Title V regulations provide for charging third parties (including government agencies) which are authorized or under legal obligation to pay for any service provided by the title V grantees, including preventive, diagnostic, and treatment services, even though the service may otherwise be provided without charge to the patient or family. Where the cost of services furnished by or through the program or project is to be reimbursed under Medicaid, a written agreement with the title XIX agency is required. This must specify whether reimbursement is to the project or directly to the provider.

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The emphasis of the 1967 title XIX amendment on payment for title V services and the revision of title V regulations to charge third party payors increased the original Medicaid responsibility to pay for title V services to Medicaid recipients.

4. Freedom of Choice Since July 1, 1969, Medicaid recipients have had the right to exercise freedom of choice of providers (Section 1902(a)(23); 42 CFR 449.20; Manual Chapter 5-100-00). This requirement does not conflict with the amendment's reference to "maximum utilization" of services of the State health and vocational rehabilitation agencies. Freedom of choice means that the client is informed about the choices available and is free to select a provider who is willing to accept Medicaid patients. The State agency carries out its responsibilities by negotiating inter-agency agreements and informing recipients about State health, vocational rehabilitation, title V and other programs.

5. Confidentiality Federal policy (Section 1902(a)(7) of the Social Security Act and 45 CFR 205.50(a)) prohibits the use or disclosure of information, including lists of names and addresses, concerning applicants and recipients of services

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without their informed consent, except for purposes directly connected with the administration of the program. This general prohibition applies to disclosure of information to service providers, without exception, since they are not considered to be directly connected with the administration of the program. State and local agencies must ensure, therefore, that they comply with Federal policy and that all such information remains confidential.

6. 75% Federal Matching 75% Federal matching is available for cost of skilled professional medical personnel and staff directly supporting such personnel employed by the title XIX agency, or by any other public agency if they assist in the administration of the Medicaid program at the State and local level (42 CFR 446.175 and Manual Chapter 2-41-00). This special matching rate is available only for those portions of time directed to the administration of the Medicaid program.

Functions or services performed or provided by another public agency for Medicaid recipients which are not required by Medicaid are not subject to Federal matching under Medicaid.

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7. Transportation Under the requirement in 42 CFR 449.10(a)(5)(ii), a State Medicaid plan must contain a commitment to assure necessary transportation of eligible recipients to and from providers of services, and a description of the methods to be used. This requirement relates to the availability of transportation as an administrative aid in carrying out the provision of medical services, and Federal matching is available at the administrative rate. State agencies have an obligation to pay for transportation only if it is not otherwise available to the recipient.

   In order to comply with this requirement, State agencies may and do use a variety of methods. In addition to the administrative requirement, States have the option of providing for some transportation as an item of medical assistance, and may claim Federal matching at the Federal medical assistance percentage. (See Manual Chapter 6-20-00).

USGPO 720-337 1302/8067

COOPERATIVE AGREEMENT BETWEEN THE DEPARTMENT OF SOCIAL SERVICES,
Division of Medical Services and
THE DEPARTMENT OF HEALTH, Division of Maternal, Child and Family Health,
Bureau of Family Health

CASE MANAGEMENT FOR PREGNANT WOMEN

STATEMENT OF PURPOSE

The Missouri Departments of Social Services (DSS) and Health (DOH), in order to provide the most efficient, effective and cost effective administration of Title XIX case management services, hereby agree to the conditions included in this Cooperative Agreement. The provision of case management services for at risk pregnant women has been determined to be an effective method of improving care and reducing costs associated with providing medical services.

The DSS, Division of Medical Services recognizes the unique relationship that the DOH has with the autonomous Local Health Departments, Community Health Centers, and Rural Health Initiative Clinics. DSS, in order to take advantage of this relationship, enters into this Cooperative Agreement with DOH for provider relations and quality assurance, including establishing standards, technical assistance, coordination, and data Management of the case management services within the limits of the resources provided for in this agreement.

The Department of Social Services and the Department of Health enter into this Cooperative Agreement with full recognition of all other existing agreements between these respective Departments which are currently included in the Title XIX State Plan. This includes all agreements with DOH, BHDA for the data evaluation related to case management.

I. MUTUAL OBJECTIVES

1. To provide a plan for the coordination of services.

2. To improve and expand prenatal and preventive health services to Medicaid eligible recipients through education, cooperative planning, reducing barriers to access to health care and follow-up activities.

3. To reduce the incidence of inadequate prenatal care thereby reducing the rate of infant mortality and low birth weight at risk babies.

II. RESPECTIVE RESPONSIBILITIES

DOSS agrees to:

1. Reimburse DOH the Title XIX federal share of actual and reasonable costs for provider relations, quality assurance, and case management services, and data entry and tabulations management provided by staff based upon a time accounting system; expense and equipment costs necessary to collect data, disseminate information, and carry out the staff functions outlined in this agreement. The rate of reimbursement for eligible administrative costs will be 50%.

The rate of reimbursement for eligible costs qualifying under regulations applicable to Skilled Professional Medical Personnel and their supporting staff (compensation, travel and training), will be reimbursed at 75%.

Changes in federal regulations affecting the matching percentage, and/or cost eligible for enhanced or administrative match, which become effective subsequent to the execution of this agreement will be applied as provided in the regulations.

2. Provide DOH access to the information necessary to properly administer the Case Management Services program.

3. Meet and consult on a regular basis, at least quarterly, with DOH on issues related to this agreement.

4. Provide notification to DOH as soon as any changes are defined in the billing process and billing requirements affecting local health departments.

DOH agrees to:

1. Employ administrative staff to provide technical assistance to the Medicaid Case Management providers.

2. Employ necessary staff to provide quality assurance activities to assess the necessity for and adequacy of medical care and services provided, and act as liaison with multiple disciplines on the medical aspects of the program.

The quality assurance activities will include statewide on-site reviews of medical records to assess appropriateness and timeliness of services performed. DSS will identify the providers' names and addresses. A monitoring tool will be utilized

that will audit service and performance criteria which will be based on the objectives and service criteria requirements set forth for case management services. Such quality assurance activities and documentation are subject to review and approval by the Department of Social Services, Division of Medical Services, counterpart quality assurance staff. Develop a data management system for entry of the risk appraisal information to determine the effects of case management. This information will be shared with DOH, Bureau of Health Data Analysis, and DSS in a timely fashion.

3. Account for the activities of the staff employed under this agreement in accordance with the provisions of OMB circular A87 and 45 CFR part 74 and 95.

4. Provide as requested by the State Medicaid Agency the information necessary to request Federal funds available under the State Medicaid match rate. Submit detailed billings and use Standard Form 269 in addition to the billings for the necessary certification by the Executive Officer of the Department of Health.

5. Return to DSS any federal funds which are deferred, and/or ultimately disallowed arising from the administrative claims submitted by DSS on behalf of DOH.

6. Maintain the confidentiality of client records and eligibility information received from DSS and use that information only in the administrative, technical assistance, coordination, and quality assurance activities authorized under this agreement.

7. Meet and consult on a regular basis, at least quarterly, with DSS on issues arising out of this agreement.

8. Conduct all activities recognizing the authority of the single state Medicaid agency in the administration of the state Medicaid Plan to issue policies, rules and regulations on program matters to including the review and approval by the Division of Medical Services of all printed material developed by the Department of Health to fulfill this agreement.

III. DESCRIPTION OF PROGRAM

Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization in order to promote the effective and efficient access to necessary comprehensive services. Case management can be conceptualized as a set of individual client goal oriented activities which organize, coordinate, and monitor service delivery based on measurable objectives.

It seeks to promote the health of clients and foster independent compliance. The services described in this document target pregnant women with Medicaid coverage.

Case management services for pregnant women are focused toward the reduction of infant mortality and low birth weight by reducing the inadequate prenatal care rate. This is accomplished by educating the client and following non-compliant pregnant women so that they will more closely follow the recommendations of their care providers. An increase in women who receive adequate prenatal care will result in fewer drop-in, high risk and at-risk deliveries thereby reducing the percentage of negative pregnancy outcomes.

Qualified Title XIX case management providers will be designated throughout the state by the Department of Social Services in conjunction with the Department of Health. All pregnant women with Medicaid coverage will be eligible to receive a risk appraisal from any recognized Medicaid provider. If they are determined to be at risk, they will be eligible to receive case management services and will be referred to a qualified participating care management provider of their choice. For all at risk individuals being case managed, an assessment will be provided from which an individualized case management plan will be developed. The client's health activities will be tracked to assist the client/family in following the plan as established. The case management agency will complete the necessary data forms and forward to DOH/BFH for tabulation.

IV. PROGRAM EVALUATION PLAN

A task force consisting of the Directors of the respective department or their designees and an equal number of other persons from their respective division chosen by the Directors shall meet at least quarterly, for the purpose of program development, review, and evaluation to discuss problems, and to develop recommendations to improve programs for better and expanded services to eligible individuals. These activities shall include consideration of-

1. The evaluation of policies, duties and responsibilities of each agency.

2. Arrangements for periodic review of the agreements and for joint planning for changes in the agreements.

3. Arrangements for continuous liaison between the divisions and departments and designated staff responsibility for liaison activities at both the state and local levels.

V. TERMS OF THIS AGREEMENT

The period of this Cooperative Agreement shall be from July 1, 1997 and remain in effect until canceled by one or both parties. This agreement may be canceled at any time, upon

agreement of both parties or by either party after giving thirty (30) days prior notice in writing to the other party, provided, however that any financial arrangement(s) pertaining to this agreement shall remain in effect and reimbursement shall be made for the period when the contract is in full force and effect. This agreement may be modified at any time by the written agreement of both parties.

Maureen E. Dempsey, M.D., Director
Missouri Department of Health

9/11/97
Date

Gary J. Stangler, Director
Missouri Department of Social Services

9-25-97
Date